LETTER OF PROTECTION

Date: [Date]

To: [Name of Physician/Medical Group]
Attn: Billing/Medical Records Department
Address: [Medical Office Address]
City, State, Zip: [City, State, Zip]

RE: [Patient Name]
DOB: [Patient Date of Birth]
Date of Incident: [Date of Accident/Injury]

Dear Doctor,

Please be advised that this office represents the above-named patient in a legal claim for personal injuries sustained in the incident referenced above. This letter serves as a formal Letter of Protection regarding the orthopedic and pain management services provided to our client.

In consideration of your agreement to provide medical evaluation, diagnostic testing, and treatment on credit, we hereby agree to protect your medical bills for the services rendered to our client. We are instructed by our client to withhold such sums from any settlement, judgment, or verdict as may be necessary to pay your outstanding balance in full.

Payment will be made directly to your office out of the proceeds of any recovery obtained on behalf of the client. This agreement does not relieve the patient of their personal responsibility for the debt should there be no recovery, or if the recovery is insufficient to cover the total medical expenses.

Please send all medical reports and itemized billing statements to our office as they become available. We request that you notify us immediately if there is any change in the treatment plan or if the patient is discharged.

By signing below, the patient authorizes and directs their attorney to honor this Letter of Protection.

Sincerely,

_____
[Attorney Name]
[Law Firm Name]

ACKNOWLEDGMENT AND AGREEMENT BY PATIENT:

I hereby authorize my attorney to pay directly to the medical provider named above any sums due for medical services rendered to me. I understand that I am ultimately responsible for all medical charges regardless of the outcome of my legal case.

_____ Date: _____
[Patient Name]